APPENDIX B

EXAMPLE HEALTH & SAFETY FORMS FOR HEALTH & SAFETY ACTIVITIES

PLAN ACCEPTANCE FORM
SITE SAFETY AND HEALTH PLAN

I have read and agree to abide by the contents of the Safety and Health Plan for the following project:

_____

_____
Name (print)

_____
Signature

_____
Date

Return to Program Health and Safety Officer before work at the site.

DRILLING/BORING MARK OUT CHECKLIST

GENERAL RULES

Done	Not Done*	
☐	☐	1. Qualified personnel must do mark out work. Contact local utilities to identify the appropriate organizations to conduct markout.
☐	☐	2. All mark out work will be verified by Parsons personnel and not be delegated to others.
☐	☐	3. Magnetometer/metal surveys are not effective if lines are not metal or if rebar/metal debris present in large amounts. Magnetometer surveys should not be used as exclusive method for utility clearance due to their inherent limitations. ASTM Method available for Magnetometer surveys (A894/A894M-00).
☐	☐	4. Test pits are recommended in public access (such as roads)/active sites. Test pits are normally expected to be done by hand, hand augering or equivalent methods.
☐	☐	5. Test pits should be at least five feet in depth. This may vary depending on the fill history of the site.
☐	☐	6. Test pits may have resistance obstacles, such as concrete, asphalt, cobblestone, frozen soil etc. These may have to be removed by other means than hand methods depending on the site.

* All "Not done" requires explanation/project safety officer approval".

ACCIDENT REPORT

EMPLOYER

1. Name: _____

2. Mail Address: _____
   (No. and Street) (City or Town) (State and Zip)

3. Location : _____
   (if different from mail address)

INJURED OR ILL EMPLOYEE

4. Name: _____ Social Sec. No.: _____
   (first) (middle) (last) Employee No: _____

5. Home Address: _____
   (No. and Street) (City or Town) (State and Zip)

6. Age: _____ 7. Sex: male ( ) female ( )

8. Date of injury or illness: _____ Time of accident: _____

9. Occupation: _____
   (specific job title, not the specific activity employee was performing at time of injury)

10. Department: _____
    (enter name of department in which injured person is employed, even though they may have been temporarily working in another department at the time of injury)

THE ACCIDENT OR OCCUPATIONAL ILLNESS

11. Place of accident of exposure: _____
    (No. and Street) (City or Town) (State and Zip)

12. Project: _____

13. Was place of accident or exposure on employer's premises? Yes ( ) No ( )

14 How did the accident occur? _____
(describe fully the events that resulted in the injury or occupational illness.

_____
Tell what happened and how. Name objects and substances involved. Give details on all factors that led to

_____
accident. Use separate sheet for additional space).

15. What was the employee doing when injured? _____
(be specific--was employee using tools or equipment

_____
or handling material?)

_____

16. WITNESS TO ACCIDENT _____
(Name) (Affiliation) (Phone No.)

_____
(Name) (Affiliation) (Phone No.)

17. Name the object or substance that directly injured the employee. ___
(for example, object that struck

_____
employee; the vapor or poison inhaled or swallowed; the chemical or radiation that irritated the skin; or in

_____
cases of strains, hernias, etc., the object the employee was lifting, pulling, etc.)

18. Did the accident result in employee fatality? Yes ( ) No ( )

19. Number of lost days ____/restricted workdays ____ resulting from injury or illness?

OTHER

20. Name and address of physician:_____
(No. and Street) (City or Town) (State and Zip)

21. If hospitalized, name and address:_____
(No. and Street) (City or Town) (State and Zip)

22. Initial diagnosis of injury/occupational illness: _____
Date of report: _____ Prepared by:_____
Official position:_____

23. Treatment rendered: ☐ first aid ☐ medical treatment

_____

_____

ACCIDENT REPORT FOLLOW-UP

Employee: _____ Date of injury or illness: _____

ANALYSIS – What caused the accident? Why did it happen:

Primary Cause:

_____
_____
_____
_____
_____

Contributing Factors:

_____
_____
_____
_____
_____

PREVENTATIVE/CORRECTIVE ACTIONS – State what will be done to prevent re-occurrence.

Immediate action:

_____
_____
_____
_____
_____

Who is responsible: _____ Completion date(s): _____

Long-Term action:

_____
_____
_____
_____
_____

Who is responsible: _____ Completion date(s): _____

Closed by: _____
Facility Health and Safety Representative Date

(For Safety Staff only)	REPORT NO.	EHOC CODE	UNITED STATES ARMY CORPS OF ENGINEERS ACCIDENT INVESTIGATION REPORT (For Use of this Form See Help Menu and USACE Suppl to AR 385-40)	REQUIREMENT CONTROL SYMBOL: CEEC-S-8(R2)

1. ACCIDENT CLASSIFICATION

PERSONNEL CLASSIFICATION	INJURY/ILLNESS/FATAL	PROPERTY DAMAGE	MOTOR VEHICLE INVOLVED	DIVING
GOVERNMENT ☐ CIVILIAN ☐ MILITARY	☐	☐ FIRE INVOLVED ☐ OTHER	☐	☐
☐ CONTRACTOR	☐	☐ FIRE INVOLVED ☐ OTHER	☐	☐
☐ PUBLIC	☐ FATAL ☐ OTHER		☐	

2. PERSONAL DATA

a. Name (Last, First, MI)	b. AGE	c. SEX ☐ MALE ☐ FEMALE	d. SOCIAL SECURITY NUMBER	e. GRADE

f. JOB SERIES/TITLE

g. DUTY STATUS AT TIME OF ACCIDENT ☐ ON DUTY ☐ TDY ☐ OFF DUTY

h. EMPLOYMENT STATUS AT TIME OF ACCIDENT ☐ ARMY ACTIVE ☐ ARMY RESERVE ☐ VOLUNTEER ☐ PERMANENT ☐ FOREIGN NATIONAL ☐ SEASONAL ☐ TEMPORARY ☐ STUDENT ☐ OTHER (Specify)

3. GENERAL INFORMATION

a. DATE OF ACCIDENT (month/day/year)	b. TIME OF ACCIDENT (Military time) hrs	c. EXACT LOCATION OF ACCIDENT	d. CONTRACTOR'S NAME (1) PRIME: (2) SUBCONTRACTOR:

e. CONTRACT NUMBER ☐ CIVIL WORKS ☐ MILITARY ☐ OTHER (Specify)

f. TYPE OF CONTRACT ☐ CONSTRUCTION ☐ SERVICE ☐ A/E ☐ DREDGE ☐ OTHER (Specify)

g. HAZARDOUS/TOXIC WASTE ACTIVITY ☐ SUPERFUND ☐ DERP ☐ IRP ☐ OTHER (Specify)

4. CONSTRUCTION ACTIVITIES ONLY (Fill in line and corresponding code number in box from list - see help menu)

a. CONSTRUCTION ACTIVITY	(CODE) #	b. TYPE OF CONSTRUCTION EQUIPMENT	(CODE) #

5. INJURY/ILLNESS INFORMATION (Include name on line and corresponding code number in box for items a, f & g - see help menu)

a. SEVERITY OF ILLNESS/INJURY	(CODE) #	B. ESTIMATED DAYS LOST	C. ESTIMATED DAYS HOSPITALIZED	D. ESTIMATED DAYS RESTRICTED DUTY

e. BODY PART AFFECTED
PRIMARY (CODE) #
SECONDARY (CODE) #

f. NATURE OF ILLNESS / INJURY (CODE) #

g. TYPE AND SOURCE OF INJURY/ILLNESS
TYPE (CODE) #
SOURCE (CODE) #

6. PUBLIC FATALITY (Fill in line and correspondence code number in box - see help menu)

a. ACTIVITY AT TIME OF ACCIDENT (CODE) #

b. PERSONAL FLOATATION DEVICE USED? ☐ YES ☐ NO ☐ N/A

7. MOTOR VEHICLE ACCIDENT

a. TYPE OF VEHICLE ☐ PICKUP/VAN ☐ AUTOMOBILE ☐ TRUCK ☐ OTHER (Specify)

b. TYPE OF COLLISION ☐ SIDE SWIPE ☐ HEAD ON ☐ REAR END ☐ BROADSIDE ☐ ROLL OVER ☐ BACKING ☐ OTHER (Specify)

c. SEAT BELTS	USED	NOT USED	NOT AVAILABLE
(1) FRONT SEAT			
(2) REAR SEAT			

8. PROPERTY/MATERIAL INVOLVED

a. NAME OF ITEM	B. OWNERSHIP	C. $ AMOUNT OF DAMAGE
(1)		
(2)		
(3)		

9. VESSEL/FLOATING PLANT ACCIDENT (Fill in line and correspondence code number in box from list - see help menu)

a. TYPE OF VESSEL/FLOATING PLANT (CODE) #

b. TYPE OF COLLISION/MISHAP (CODE) #

10. ACCIDENT DESCRIPTION (Use additional paper, if necessary)

See attached page.

11. CAUSAL FACTOR(S) *(Read Instruction Before Completing)*

(Explain YES answers in item 13)	YES	NO
DESIGN: Was design of facility, workplace or equipment a factor?	☐	☐
SPECTION/MAINTENANCE: Were inspection & maintenance procedures a factor?	☐	☐
PERSON'S PHYSICAL CONDITION: In your opinion, was the physical condition of the person a factor?	☐	☐
OPERATING PROCEDURES: Were operating procedures a factor?	☐	☐
JOB PRACTICES: Were any job safety/health practices not followed when the accident occurred?	☐	☐
HUMAN FACTORS: Did any human factors such as, size or strength of person, etc., contribute to accident?	☐	☐
ENVIRONMENTAL FACTORS: Did heat, cold, dust, sun, glare, etc., contribute to the accident?	☐	☐

a. *(CONTINUED)*

	YES	NO
CHEMICAL AND PHYSICAL AGENT FACTORS: Did exposure to chemical agents, such as dust, fumes, mists, vapors or physical agents, such as, noise, radiation, etc., contribute to accident?	☐	☐
OFFICE FACTORS: Did office setting such as, lifting office furniture, carrying, stooping, etc., contribute to the accident?	☐	☐
SUPPORT FACTORS: Were inappropriate tools/resources provided to properly perform the activity/task?	☐	☐
PERSONAL PROTECTIVE EQUIPMENT: Did the improper selection, use or maintenance of personal protective equipment contribute to the accident?	☐	☐
DRUGS/ALCOHOL: In your opinion, was drugs or alcohol a factor to the accident	☐	☐

b. WAS A WRITTEN JOB/ACTIVITY HAZARD ANALYSIS COMPLETED FOR TASK BEING PERFORMED AT TIME OF ACCIDENT?

☐ YES *(If yes, attach a copy.)* ☐ NO

12. TRAINING

a. WAS PERSON TRAINED TO PERFORM ACTIVITY/TASK? ☐ YES ☐ NO

☐ CLASSROOM ☐ ON JOB

DATE OF MOST RECENT FORMAL TRAINING (Month) (Day) (Year)

13. FULLY EXPLAIN WHAT ALLOWED OR CAUSED THE ACCIDENT; INCLUDE DIRECT AND INDIRECT CAUSES *(See instruction for definition of direct and indirect causes.) (Use additional paper, if necessary)*

a. DIRECT CAUSE

See attached page.

b. INDIRECT CAUSE(S)

See attached page.

14. ACTION(S) TAKEN, ANTICIPATED OR RECOMMENDED TO ELIMINATE CAUSE(S).

DESCRIBE FULLY:

See attached page.

DATES FOR ACTIONS IDENTIFIED IN BLOCK 14.

BEGINNING (Month/Day/Year)

b. ANTICIPATED COMPLETION (Month/Day/Year)

c. SIGNATURE AND TITLE OF SUPERVISOR COMPLETING REPORT	d. DATE *(Mo/Da/Yr)*	e. ORGANIZATION IDENTIFIER *(Div, Br, Sect)*	f. OFFICE SYMBOL
CORPS _____			
CONTRACTOR _____			

16. MANAGEMENT REVIEW *(1st)*

a. ☐ CONCUR b. ☐ NON CONCUR c. COMMENTS

SIGNATURE	TITLE	DATE

17. MANAGEMENT REVIEW *(2nd - Chief Operations, Construction, Engineering, etc.)*

a. ☐ CONCUR b. ☐ NON CONCUR c. COMMENTS

SIGNATURE	TITLE	DATE

18. SAFETY AND OCCUPATIONAL HEALTH OFFICE REVIEW

a. ☐ CONCUR b. ☐ NON CONCUR c. ADDITIONAL ACTIONS/COMMENTS

SIGNATURE	TITLE	DATE

19. COMMAND APPROVAL

COMMENTS

)MMANDER SIGNATURE | DATE

*U.S. GOVERNMENT PRINTING OFFICE: 1993-0-791-757

10. ACCIDENT DESCRIPTION *(Continuation)*

DIRECT CAUSE *(Continuation)*

13b. INDIRECT CAUSES *(Continuation)*

14. ACTION(S) TAKEN, ANTICIPATED, OR RECOMMENDED TO ELIMINATE CAUSE(S) *(Continuation)*

USACE Abbreviated Accident Prevention Plan (AAPP)